

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

January 4, 2018

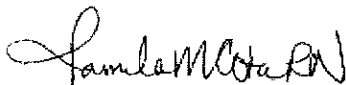
Ms. Michelle Sharron, Manager
Pleasant Street House
59 South Pleasant Street
Randolph, VT 05060-1344

Dear Ms. Sharron:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on December 13, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

JAN 02 2018

PRINTED: 12/21/2017
FORM APPROVED

Division of Licensing and Protection

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0296 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 12/13/2017 |
| NAME OF PROVIDER OR SUPPLIER PLEASANT STREET HOUSE | | STREET ADDRESS, CITY, STATE, ZIP CODE 59 SOUTH PLEASANT STREET RANDOLPH, VT 05060 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R100 | Initial Comments: An unannounced re-licensure survey was conducted by the Division of Licensing and Protection on 12/13/17. The following Residential Care Home Licensing Regulations violations were identified: | R100 | | |
| R126 SS=D | V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to provide the necessary care, assessment and interventions to address the ongoing use of full bed rails for 2 of 2 applicable residents. (Resident #1 & 2) Findings include: 1. During the environmental tour of the facility accompanied by the manager on the morning of 12/13/17 full bed rails were observed attached to Resident #1's bed. The manager acknowledged Resident #1 uses the bed rails for repositioning. Per review of the Resident Assessment last completed on 6/6/17 the nurse had assessed the resident as "independent with bed mobility". Further review of the bed rail noted spacing of approximately 5-6 inches between the top portion of each rail and the middle rail creating the potential for entrapment of Resident #1's | R126 | 1. Quarter side rails have been ordered for Resident #1's bed. Once installed, staff will work with the resident to assess how he might best be able to use these railings to reposition himself enough to be comfortable. 2. The bed used for Resident #2 has already been replaced with a lower bed that will not necessitate the use of bed rails. If beds (or attachments to beds) are altered in the future for any of the three Pleasant Street residents, the manager will consult with Licensing to assure compliance. Although the memorandum of December 16, 2016 had been reviewed by the manager and her supervisor, | (Estimated) 2/1/18 12/28/17 |

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

0007

410011

If continuation sheet 1 of 5

R126-R266 POC accepted 1/3/18 SShenbrock/pnw

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| R126 | Continued From page 1 extremities and possible harm. The manager stated there had been no consideration or assessment for the discontinuation of the full bed rails for Resident #1. 2. Also noted during the facility tour, full bed rails were observed attached to the bed utilized for Resident #2. The manager confirmed Resident #2 had a previous history of falling out of bed and a low bed had been used in the past. However, after Resident #2 experienced a serious illness the manager stated the resident no longer posed a potential threat for falling out of bed and lacked bed mobility resulting in being provided the present bed with full bed rails attached and utilized daily. On the side of the bed positioned against a bedroom wall a gap was also observed between the bed rail and the mattress, posing the potential for entrapment. The observation was confirmed by the manager during the environmental tour. As a result of the observation, the manager placed a long pillow on the side of the bed where the gap was noted and began discussion with a supervisor to obtain a low bed for Resident #2. | R126 | they had not appreciated the safety risks they posed for the two residents. In the future, when assessing for safety we will seek the Division's expertise in making these determinations. Corrective action for Resident #1's bed will be completed within two weeks of the receipt of new railings. | |
| R135 SS=D | V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. | R135 | Sections M a and M c will be revised when the new railings for Resident #1's bed are installed. In revising the Resident Assessment for Resident #1, clarification will be provided. | Estimated by 2/15/18 |

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| R135 | Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and confirmed during telephone interview, the nurse failed to accurately complete the Resident Assessment for 1 of 3 applicable residents. (Resident #1) Findings include: Per review of the Resident Assessment dated 6/6/17 for Resident #1, the nurse failed to accurately complete the assessment regarding the use of full bed rails. Although Resident #1's has full bed rails attached and utilized on his/her bed, the nurse records in section "M a." bed rails were not being used. The nurse further documents in section "M c." that "other types of side rails" were used daily (e.g. half rail, one side) "for positioning". However, per interview with the facility manager, confirmed Resident #1 has utilized full bed rails daily for years. The nurse also documented Resident #1 was receiving Hospice services. Resident #1 has not enrolled or guardians accepted the Hospice benefit provided by a certified Home Health Agency & Hospice or Palliative care services. The resident is receiving comfort care which is being presently managed by the resident's attending physician. Specific to this Resident Assessment, it was also noted not all required information was completed. | R135 | to state that, while this resident is <u>eligible</u> for Hospice care through an outside agency, he is currently receiving comfort care under the management of his primary care physician. Resident #1, and his guardian, have a long and trusting relationship with this physician. There is recognition that additional services may be utilized when his needs increase, and he may require a greater level of intervention. The house manager will review the revised assessment to ensure that it is clear, correct and complete and will share the document with her supervisor as well. The revised assessment will be completed and reviewed within two weeks from the installation of the new bed railings. | |
| R266 SS-D | IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. | R266 | | |

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| R266 | Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to assure a safe environment at all times specifically related to the use of full bed rails for 2 applicable residents. (Resident #1 & #2) Findings include: 1. During the environmental tour of the facility accompanied by the manager on the morning of 12/13/17 full bed rails were observed attached to Resident #1's bed. The manager acknowledged Resident #1 uses the bed rails for reposition. Further review of the bed rail noted spacing of approximately 5-6 inches between the top portion of each rail and the middle rail creating the potential for entrapment of Resident #1's extremities and possible harm. The manager stated there had been no consideration or assessment for the discontinuation of the full bed rails for Resident #1. 2. Also noted during the facility tour full bed rails were observed attached to the bed utilized for Resident #2. The manager confirmed Resident #2 had a previous history of falling out of bed and a low bed had been used in the past. However, after Resident #2 experienced a serious illness, the manager stated the resident no longer posed a potential threat for falling out of bed and lacked bed mobility resulting in being provided the present bed with full bed rails attached and utilized daily. On the side of the bed positioned against a bedroom wall a gap was also observed between the bed rail and the mattress, posing the potential for entrapment. The observation was confirmed by the manager during the environmental tour. | R266 | The railings for Resident #1's bed will be replaced as soon as the new railings are delivered. Resident #2's bed has already been replaced and has no rails. In the future, when safety memorandums are issued, a more thorough, informed assessment of risk will be completed and documented. If applicability is not immediately obvious, clarification will be sought from the Division, and consultation with other professionals will take place if necessary (OT, PT, etc). | Estimated by 12/18 12/28/17 |

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| R266 | Continued From page 4 A risk assessment and continued use of the full bed rails for either resident was not completed or considered to assure both residents were provided a safe environment and free from potential harm of entrapment. | R266 | This facility appreciates any observations that will result in greater safety for our residents. | | |